Wisconsin Department of Regulation & Licensing

Mail To: P.O. Box 8935
Madison, WI 53708-8935

1400 E. Washington Avenue
Madison, WI 53703

FAX #: (608) 261-7083
Phone #: (608) 266-2112

E-Mail: web@drl.state.wi.us
Website: http://www.drl.state.wi.us

APPLICATION INFORMATION FORM

ATTENTION

IMPORTANT INFORMATION PLEASE READ

Enclosed is the application packet you recently requested from the Wisconsin Department of Regulation and Licensing.

To avoid any unnecessary errors, take a moment to review the entire application packet before you begin to complete your application.

We will mail you a check sheet within 10-15 *working* days after receipt of your application in this office. The check sheet will include an identification number that allows you to check the status of your application by calling the **Interactive Voice Response System, (608) 261-7925.** The Interactive Voice Response System will inform you of any requirements not met. You may also check the status of your application on our web-site: http://www.drl.state.wi.us. Look under "Applicant Services."

It is your obligation as an applicant to see that the items listed as "Is Required" are forwarded to the Department of Regulation and Licensing. The Department will not contact other agencies or jurisdictions for information/documents to complete your application. We will update check sheets within 3-5 working days *of receipt* of documents. An application is not considered complete until we receive all the required documents and fees.

Once your application is complete, check the department's web-site: http://www.drl.state.wi.us. Look under "Business/Professional License Lookup" for your official credential number and grant date.

#2070 (Rev. 4/02)
Ch. 15.40, Stats.

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MEDICAL EXAMINING BOARD

APPLICATION **FOR RE-REGISTRATION** OF LICENSE TO PRACTICE MEDICINE AND SURGERY

Wisconsin Statutes provide that the board may require an individual who has not registered for five consecutive years to demonstrate his fitness to practice before permitting such person to be re-registered.

PLEASE TYPE OR PRINT IN INK

☐ Your name and address are available to the public.
Check box if you wish your name & address withheld from lists of 10 or more credential holders (sec. 440.14, Stats.).

Last Name	First Name	MI	Former / Maiden Name(s)

Your Street Address (number, street, city, state, zip)

Mail To Address (if different)

Date of Birth

_____ _____ _____
month day year

Daytime Telephone Number

( ) _____ - _____

Ethnic/gender status information is optional.

Sex: ☐ M ☐ F

Ethnic: ☐ White, not of Hispanic origin ☐ Black, not of Hispanic origin ☐ Hispanic ☐ American Indian or Alaskan ☐ Asian or Pacific Islander ☐ Other

Medical School: _____

School Address: _____
(City) (State)

Date Diploma Granted: _____
month/day/year

Degree: _____

Specialty: _____

Specialty Code: _____

BOARD OFFICE USE ONLY
School Code: _____
Procedure Code: _____

APPLICATION FEES (Make check payable to Department of Regulation and Licensing and attach to application).

For Receipting Use Only

$106.00 Re-Registration Fee
$ 57.00 State Law Exam
$ 25.00 Late Renewal Fee
$188.00 *Total fee attached

***ORAL EXAMINATION FEE: $266.00**
If you should be selected for an oral examination, the additional oral examination fee will be required prior to being scheduled for the exam.

#1542 (Rev. 03/03)
Ch. 448, Stats.

State of Wisconsin Department of Regulation & Licensing

APPLICATION IS NOT COMPLETE UNTIL ALL OF THE FOLLOWING DOCUMENTS HAVE BEEN RECEIVED:

Fee attached to application (Form #1542).

Work History (Form 1934).

Employment Verification Form (Form #2166).

Hospital Verification-Privileges, Employment or Appointment (Form #2167).

Physician Profile Data Report from the American Medical Association or American Osteopathic Association.

Signed Authorization & Waiver Form (#571).

Disciplinary Inquiry Report from the Federation of State Medical Boards (Form #1445).

National Practitioner Data Bank Report (See instructions to obtain).

Letters from all State Boards where licensed (includes active and inactive licenses).

Wisconsin Statutes and Rules Examination Booklet with answer sheet.

Copies of malpractice suit. Court documents with allegations and settlement.

Convictions & Pending Charges form (if applicable.)

Copies of Continuing Medical Education credits. 30 hours of Category I AMA or AOA. Biennium from 1/1/even – 12/31/odd

IS NAME ON ALL CREDENTIALS THE SAME? IF NOT, SUBMIT CERTIFIED COPY OF MARRIAGE CERTIFICATE, DIVORCE DECREE, ETC.

PROFESSIONAL EDUCATION: (schools, locations, dates of graduation and degrees) (list all schools attended)

	SCHOOL	DEGREE	DATES OF GRADUATION
1.			
2.			
3.			
4.			

POST-GRADUATE TRAINING AND ACTIVITIES: (Outline in chronological order all activities <u>from the date of graduation from medical school to the present time</u>. Must include professional and nonprofessional activities. All activities must be accounted for.

	NAME OF HOSPITAL OR CLINIC	LOCATION	DATES (from - to) mo/yr
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

ECFMG EXAM TAKEN	CERTIFICATE ISSUED	CERTIFICATE NO.	DATE ISSUED

SPECIALTY BOARD CERTIFICATIONS DATE CERTIFIED

State of Wisconsin Department of Regulation & Licensing

LIST ALL HOSPITALS THAT YOU HAVE HAD STAFF PRIVILEGES, EMPLOYMENT OR APPOINTMENTS DURING THE LAST 5 YEARS:

	NAME OF HOSPITAL	LOCATION	DATES (from-to) mo/yr
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

I AM LICENSED IN THE FOLLOWING STATES (UNLIMITED):

By Written Exam: _____

By Endorsement/Reciprocity: _____

YOU ARE REQUIRED TO HAVE EACH STATE BOARD IN WHICH YOU HAVE EVER BEEN LICENSED SUBMIT LETTERS OF VERIFICATION TO THE WISCONSIN MEDICAL EXAMINING BOARD. THE LETTERS MUST INDICATE YOUR DATE OF BIRTH, LICENSE NUMBER, DATE OF ISSUANCE, AND A STATEMENT REGARDING DISCIPLINARY ACTIONS. THESE LETTERS WILL BE REQUIRED IN ORDER TO COMPLETE YOUR APPLICATION FOR LICENSURE.

ANSWER THE FOLLOWING QUESTIONS: (Attach additional sheets if necessary).

		YES	NO
1.	Are you familiar with the state health laws and rules and regulations of the Wisconsin Department of Health and Family Services regarding communicable diseases?	☐	☐
2.	Have you ever surrendered, resigned, cancelled or been denied a professional license or other credential in Wisconsin or any other jurisdiction? If yes, give details on an attached sheet, including the name of the profession and the agency.	☐	☐
3.	Have you ever failed to pass any state board examination, national board examination, or USMLE, or FLEX examination? If yes, give details on an attached sheet.	☐	☐
4.	Has any licensing or other credentialing agency ever taken any disciplinary action against you, including but not limited to, any warning, reprimand, suspension, probation, limitation, revocation? If yes, attach a sheet providing details about the action, including the name of the credentialing agency and date of action.	☐	☐
5.	Is disciplinary action pending against you in any jurisdiction? If yes, attach a sheet providing details about pending action, including the name of the agency and status of action.	☐	☐
6.	Do you have any felony or misdemeanor charges pending against you? If yes, attach a sheet providing details about the pending charge, copy of the court documents and status of the charge. (Please do not give details on minor traffic charges, but do include information relating to Driving While Intoxicated (DWI) charges.)	☐	☐
7.	Have you ever been convicted of a misdemeanor or a felony? If yes, attach a sheet providing details about the crime, including date of conviction, penalty and a copy of the court documents. (Please do not give details on minor traffic convictions, but do include information relating to Driving While Intoxicated (DWI) charges.)	☐	☐

		YES	NO
8.	Are you incarcerated, on probation or on parole for any conviction? If applicable, attach a sheet providing details including the terms of incarceration and a copy of a report from your probation or parole officer.	☐	☐
9.	Have any suits or claims ever been filed against you as a result of professional services? If yes, submit a copy of the claim or suit and a copy of the final settlement or disposition.	☐	☐
10.	Have your hospital privileges ever been limited or removed? If yes, give details on an attached sheet.	☐	☐
11.	Are you registered or licensed in any other profession(s)? If yes, state what profession(s) and in what states(s).	☐	☐
12.	Have you ever been credentialed under any other name(s)? If yes, state name(s) credentialed under.	☐	☐
13.	Has the Drug Enforcement Administration ever withdrawn your DEA number or warned you, or have you been denied a DEA number? If yes, give details on an attached sheet.	☐	☐

For the purposes of these questions, the following phrases or words have the following meanings:

"Ability to practice medicine" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or **within the past two years.**

"Illegal use of controlled dangerous substances" means the use of controlled dangerous substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled dangerous substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

		YES	NO
14.	Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? If yes, please explain.	☐	☐
15.	Does your use of chemical substance(s) in any way impair or limit your ability to practice medicine with reasonable skill and safety? If yes, please explain.	☐	☐
16.	Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? If yes, please explain.	☐	☐
17.	Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice? If yes, please explain.	☐	☐

		YES	NO
18.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism? If yes, please explain.	☐	☐
19.	Are you currently engaged in the illegal use of controlled dangerous substances?	☐	☐
20.	If yes, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? If yes, please explain.	☐	☐

AFFIDAVIT OF APPLICANT

(Sign and date in the presence of a notary)

I state that I am the person referred to on this application and that all the answers set forth are each and all strictly true in every respect. I understand that false or forged statements made in connection with this application may be grounds for revocation of my credential. I also understand that if I am issued a credential, failure to comply with the laws or rules of either the Medical Examining Board or the Wisconsin Department of Regulation and Licensing will be cause for disciplinary action.

_____
Signature of Applicant

State of _____ County of_____

Subscribed and sworn to before this _____ day of

_____, 20_____, by _____
(Applicant name)

_____
Signature of Notary Public

SEAL

_____
Date Commission Expires

SOCIAL SECURITY NUMBER. Your social security number (or employer identification number if you are applying as a business entity) must be submitted with your application on this form. If you do not have a social security number you must submit a statement under oath or affirmation. If your social security number or a statement is not provided, your application will be denied.[1] A form for submitting a statement that you do not have a social security number is available from the department.

(Please Print)

First Name Middle Initial Last Name

Profession

Date of Birth _____ month _____ day _____ year

☐☐☐ - ☐☐ - ☐☐☐☐

Social Security Number or FEIN

The Department may not disclose the social security number collected above except to the Department of Workforce Development for purposes of administering the child and spousal support program,[2] to the Department of Revenue for the purpose of determining whether you are liable for delinquent taxes,[3] and to the federal Healthcare Integrity and Protection Data Bank for the purpose of reporting adverse actions against health care practitioners.[4]

[1] Section 440.03 (11m), Wis. Stats.
[2] Sections 49.22, and 440.13, Wis. Stats.
[3] Section 440.12, Wis. Stats.
[4] Health Insurance Portability and Accountability Act (HIPAA) of 1996

This form is authorized by secs. 440.12 and 440.14, Wis. Stats. Making a false statement in connection with this application may result in revocation or denial.

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WORK HISTORY
MEDICINE AND SURGERY

MEDICAL EXAMINING BOARD

COMPLETE WORK HISTORY. If you have never been employed, stop at box 7. Photocopy this form if additional space is required.

1. NAME / LAST _____ **FIRST** **MI**		**2. DATE OF BIRTH** ___ ___ / ___ ___ / ___ ___
3. ADDRESS (Street, City, State, Zip Code)		
4. MAIDEN OR GIVEN SURNAME _____	**5. CHECK HERE IF YOU HAVE NEVER BEEN EMPLOYED:** _____	**6. DATE FORM COMPLETED:** _____

7. RECORD WORK HISTORY CHRONOLOGICALLY - Complete Work History beginning with present employment and concluding with graduation from medical school. You must account for the entire time period including periods of unemployment and volunteer work, etc.

A. NAME OF BUSINESS INSTITUTION:	**JOB TITLE:**
ADDRESS: (Street, City, State, Zip Code)	**DESCRIPTION OF DUTIES PERFORMED:**
SUPERVISOR NAME: _____	
DATE OF EMPLOYMENT/ ATTENDANCE: From: ___ ___ / ___ ___ / ___ ___ Month Day Year; To: ___ ___ / ___ ___ / ___ ___ Month Day Year	**HOURS WORKED PER WEEK:** _____
	TYPE OF EMPLOYMENT: _____ Full-time _____ Part-time
TOTAL TIME WORKED (Yr./Mo.)	

B. NAME OF BUSINESS INSTITUTION:	**JOB TITLE:**
ADDRESS: (Street, City, State, Zip Code)	**DESCRIPTION OF DUTIES PERFORMED:**
SUPERVISOR NAME: _____	
DATE OF EMPLOYMENT/ ATTENDANCE: From: ___ ___ / ___ ___ / ___ ___ Month Day Year; To: ___ ___ / ___ ___ / ___ ___ Month Day Year	**HOURS WORKED PER WEEK:** _____
	TYPE OF EMPLOYMENT: _____ Full-time _____ Part-time
TOTAL TIME WORKED (Yr./Mo.)	

State of Wisconsin Department of Regulation & Licensing

C. NAME OF BUSINESS INSTITUTION:

JOB TITLE:

ADDRESS: (Street, City, State, Zip Code)

DESCRIPTION OF DUTIES PERFORMED:

SUPERVISOR NAME: _____

DATE OF EMPLOYMENT/ ATTENDANCE:

From: ___ ___ / ___ ___ / ___ ___
Month Day Year

To: ___ ___ / ___ ___ / ___ ___
Month Day Year

HOURS WORKED PER WEEK: _____

TYPE OF EMPLOYMENT:

_____ Full-time
_____ Part-time

TOTAL TIME WORKED (Yr./Mo.)

D. NAME OF BUSINESS INSTITUTION:

JOB TITLE:

ADDRESS: (Street, City, State, Zip Code)

DESCRIPTION OF DUTIES PERFORMED:

SUPERVISOR NAME: _____

DATE OF EMPLOYMENT/ ATTENDANCE:

From: ___ ___ / ___ ___ / ___ ___
Month Day Year

To: ___ ___ / ___ ___ / ___ ___
Month Day Year

HOURS WORKED PER WEEK: _____

TYPE OF EMPLOYMENT:

_____ Full-time
_____ Part-time

TOTAL TIME WORKED (Yr./Mo.)

E. NAME OF BUSINESS INSTITUTION:

JOB TITLE:

ADDRESS: (Street, City, State, Zip Code)

DESCRIPTION OF DUTIES PERFORMED:

SUPERVISOR NAME: _____

DATE OF EMPLOYMENT/ ATTENDANCE:

From: ___ ___ / ___ ___ / ___ ___
Month Day Year

To: ___ ___ / ___ ___ / ___ ___
Month Day Year

HOURS WORKED PER WEEK: _____

TYPE OF EMPLOYMENT:

_____ Full-time
_____ Part-time

TOTAL TIME WORKED (Yr./Mo.)

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EMPLOYMENT VERIFICATION FORM FOR EMPLOYERS OTHER THAN HOSPITALS

MEDICAL EXAMINING BOARD

IMPORTANT: *PLEASE FORWARD THIS FORM TO ALL EMPLOYERS DURING THE LAST 5 YEARS (This form may be photocopied).*

The **State of Wisconsin** requests that you complete this form concerning the following individual:

PHYSICIAN'S NAME: _____

EMPLOYER'S NAME: _____

EMPLOYER'S ADDRESS: _____

EMPLOYER'S TELEPHONE: _____

1. What position did this physician hold when employed by you? _____
2. What were this physician's dates of employment? _____

		YES	NO
3.	Did this physician leave your employ in good standing? If no, please attach explanation on a separate sheet.	☐	☐
4.	Was the physician on probation, suspended or in any way sanctioned/disciplined while employed by you? If yes, please attach explanation on a separate sheet.	☐	☐
5.	Was this physician granted a leave of absence while employed by you? If yes, please attach explanation on a separate sheet.	☐	☐
6.	Were any restrictions or special requirements placed on this physician's activities which were not placed on all other employees holding similar positions? If yes, please attach explanation on a separate sheet.	☐	☐
7.	Was this physician denied hospital privileges while employed by you? If yes, please attach explanation on a separate sheet.	☐	☐
8.	Were any restrictions or special requirements placed on this physician's hospital privileges? If yes, please attach explanation on a separate sheet.	☐	☐
9.	Were any formal patient or staff complaints filed against this physician? If yes, please attach explanation on a separate sheet.	☐	☐

State of Wisconsin Department of Regulation & Licensing

		YES	NO
10.	Were any incident reports filed involving the professional conduct or behavior of this physician? If yes, please attach explanation on a separate sheet.	☐	☐
11.	Was this physician ever subject to a non-routine monitoring while in your employ? If yes, please attach explanation on a separate sheet.	☐	☐
12.	Was this physician removed from a call schedule for cause? If yes, please attach explanation on a separate sheet.	☐	☐

Print name of Employer Supplying Information _____

Signature of Employer Supplying Information _____

Date form was completed _____

PLEASE ATTACH LETTERHEAD FROM THE FACILITY WHERE THE APPLICANT WORKED OR SUPPLY SOME FORM OF IDENTIFICATION FOR INDIVIDUAL SUPPLYING INFORMATION.

Please return directly to:

Department of Regulation and Licensing
Medical Examining Board
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

Wisconsin Department of Regulation & Licensing

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HOSPITAL VERIFICATION - PRIVILEGES, EMPLOYMENT OR APPOINTMENT

MEDICAL EXAMINING BOARD

IMPORTANT: *PLEASE FORWARD THIS FORM TO ALL HOSPITALS THAT YOU HAVE HAD STAFF PRIVILEGES DURING THE LAST 5 YEARS (This form may be photocopied).*

The **State of Wisconsin** requests that you complete this form concerning the following individual:

PHYSICIAN'S NAME: _____

HOSPITAL/FACILITY: _____

HOSPITAL/FACILITY ADDRESS: _____

HOSPITAL/FACILITY TELEPHONE: _____

1. What position did this physician hold at your facility? _____
2. What were this physician's dates of employment or staff privileges at your facility? _____

	YES	NO
3. Was the physician placed on probation, suspended or in any way sanctioned/disciplined while at your facility? If yes, please attach explanation on a separate sheet.	☐	☐
4. Was this physician granted a leave of absence while employed at your facility? If yes, please attach explanation on a separate sheet.	☐	☐
5. Did this individual have a record of unexcused absences during his/her attendance at this facility?	☐	☐
6. Were any restrictions or special requirements placed on this physician's activities that were not placed on all other employees/staff holding similar positions? If yes, please attach explanation on a separate sheet.	☐	☐
7. Were any restrictions placed on this physician's privileges? If yes, please attach explanation on a separate sheet.	☐	☐
8. Were any formal patient or staff complaints filed against this physician? If yes, please attach explanation on a separate sheet.	☐	☐
9. Were any incident reports filed involving the professional conduct or behavior of this physician? If yes, please attach explanation on a separate sheet.	☐	☐

State of Wisconsin Department of Regulation & Licensing

		YES	NO
10.	Was this physician ever subject to non-routine monitoring while at your facility? If yes, please attach explanation on a separate sheet.	☐	☐
11.	Was this physician involuntarily removed from a call schedule for cause? If yes, please attach explanation on a separate sheet.	☐	☐
12.	Was this physician subject to non-routine quality assessment review? If yes, please attach explanation on a separate sheet.	☐	☐
13.	Was this physician the subject of a negative review by a quality assurance or departmental committee? If yes, please attach explanation on a separate sheet.	☐	☐

Name and Title of Certifying Official

Date

SEAL OF HOSPITAL
(If hospital does not have a seal, a letter attesting to this fact, on hospital stationery, must accompany this certificate)

Please return directly to:

Department of Regulation and Licensing
Medical Examining Board
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

American Medical Association

Physicians dedicated to the health of America

AMA Physician Profile Unit
515 North State St
Chicago, IL 60610

Telephone: 312 464-5199
Fax: 312 464-5900

AMA Physician Profile Order Form -- Physician Use Only

Complete and send this form to the American Medical Association (AMA) at the above address. Profiles also can be ordered online through ***AMA ePhysician Profiles*** located at http://www.ama-assn.org/AMAPhysicianProfiles. AMA Customer Service is available for ordering assistance at 800-665-2882 or 312-464-5199, Monday through Friday, 8:30am - 4:45pm CT.

******Join or renew your AMA membership today---call 800-AMA-3211******

Indicate AMA Membership Status: _____Member Physician _____Nonmember Physician

Membership Type	**Standard Mail Service*** (within 10 business days)	**Express Service*** (within 5 business days)
AMA Member Physician	No charge	$6 per profile
Nonmember Physician	$26 per profile	Not available

****Prices are subject to change without advance notice.***

Credit card payment is preferred as check payments may extend processing time. Checks should be made payable to the American Medical Association, Remittance Control Area/PPS, Accounting Department, PO Box 109054, Chicago, IL 60610. Orders faxed to the AMA must include credit card information for billing purposes.

___ VISA ___ American Express ___ MasterCard Charge Amount: **$**_____

Credit Card Number _____Expiration Date: ____/____/____

Name on Credit Card: _____

Billing Address:_____

Approval Signature_____ Daytime Telephone: _____

Part 1: AMA Physician Profile Delivery Information

Please send my profile to the following state licensing or medical specialty board:

Board Name: _____

NOTE: When requesting delivery to a state licensing board, indicate MD or DO profession type.

Part 2: Physician Information

_____
Physician Name (first, middle, last, suffix)

_____ ____/____/____ _____
Place of Birth Date of Birth Social Security Number

_____ _____
E-mail Address Medical Education Number (optional)

_____
Preferred Mailing Address

_____ (_____)_____-_____
City, State, Zip Code Telephone Number

The above address is my OFFICE ___ HOME ____ OTHER ___

If address is home or other, please complete this section.

_____
Primary Office Address

_____ (____)_____-_____
City State Zip Code Office Telephone Number

Part 3: Medical Education and Other Information

Medical School of Graduation _____ Year of Graduation _____

DEA Number _____ ECFMG Number _____

Residency Training

Residency Training (institution/hospital name, location, and years) _____

_____

_____

Hospital Admitting Privileges

Hospital Name _____ City/State _____

_____ _____

_____ _____

_____ _____

Group Practice Affiliation(s)

Group Practice Name _____ City/State _____

_____ _____

_____ _____

_____ _____

Physician Agreement

Agreement must be signed in order to process your request.
AMA endeavors to maintain its physicians' records with information that is complete, current, and timely; however, because of possible reporting and processing delays, no representations or warranties as to the accuracy or completeness can be or is made. In consideration of the receipt of your physician record provided by AMA, hereby release AMA, its agents and servants from any and all liability whatsoever for inaccurate or incomplete information in such physician record. Submission of this form and payment of fee (if applicable) shall be conclusive evidence of your understanding and agreement to the above stated terms and conditions.

X_____ _____/_____/_____
Signature Date

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REQUEST FOR PHYSICIAN PROFILE DATA

MEDICAL EXAMINING BOARD

FEES:

AOA Members - No Charge
Non-Members - $20.00

APPLICANT: PLEASE COMPLETE THIS FORM AND FORWARD TO THE AMERICAN OSTEOPATHIC ASSOCIATION AT THIS ADDRESS:

American Osteopathic Association
Physicians' Biographic Records
142 East Ontario St.
Chicago IL 60611-2864
800-621-1773, Ext. 8145
FAX: (312) 202-8206
AOA Website (www.aoa-net.org)

The **State of Wisconsin** requests a physician profile concerning the following individual:

NAME	DAYTIME PHONE NUMBER
ADDRESS	DAYTIME PHONE NUMBER
CITY, STATE AND ZIP	YEAR OF GRADUATION (from Med. Sch) DEGREE
DATE OF BIRTH	E.C.F.M.G. NUMBER
SOCIAL SECURITY NUMBER	AOA NUMBER
	Physician's Signature **Date**

ATTENTION: AMERICAN OSTEOPATHIC ASSOCIATION

Please mail the response directly to the Wisconsin Medical Examining Board at the following address:

Department of Regulation & Licensing
Medical Examining Board
PO Box 8935
Madison WI 53708

#1935 (Rev. 01/03/03)
Ch. 448, Stats.

Wisconsin Department of Regulation & Licensing

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MEDICAL EXAMINING BOARD

BOTH FORMS MUST BE SIGNED AND NOTARIZED IN BOTH SPACES PROVIDED

AUTHORIZATION AND WAIVER

Name	City/State/Country of Birth	Date of Birth

having filed an application for a license to practice medicine and surgery in the State of Wisconsin, hereby authorize and consent to have an investigation made as to my professional reputation and fitness for the practice of medicine and surgery. I agree to give any further information which may be required in reference to my past record. I understand that I may inspect and copy any reports received by the Board relating to my professional reputation and fitness for the practice of medicine and surgery and that I may submit evidence including documents which tend to mitigate or explain any adverse information received from other parties. I also understand that the contents of my report will be privileged as to all other persons unless determined otherwise by court order.

I also authorize and request every person, hospital, clinic, community, governmental agency, court, association or institution having control of any documents, records and other information pertaining to me, to furnish to the Wisconsin Medical Examining Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any of its pertinent data and to permit the Wisconsin Medical Examining Board or any of its agents or representatives to inspect and make copies of such documents, records and other information.

I hereby release, discharge, exonerate the Wisconsin Medical Examining Board, its agents and representatives, and any person so furnishing information from any and all liability of every nature and kind arising out of the furnishing or inspection of such documents, records and other information or the investigation made by the Wisconsin Medical Examining Board.

_____
Signature of Applicant

State of _____ County of _____

Subscribed and sworn to before this _____ day of

_____, 20____, by _____
(Applicant name)

_____ _____
Signature of Notary Public Date Commission Expires

AUTHORIZATION AND WAIVER

Name	City/State/Country of Birth	Date of Birth

having filed an application for a license to practice medicine and surgery in the State of Wisconsin, hereby authorize and consent to have an investigation made as to my professional reputation and fitness for the practice of medicine and surgery. I agree to give any further information which may be required in reference to my past record. I understand that I may inspect and copy any reports received by the Board relating to my professional reputation and fitness for the practice of medicine and surgery and that I may submit evidence including documents which tend to mitigate or explain any adverse information received from other parties. I also understand that the contents of my report will be privileged as to all other persons unless determined otherwise by court order.

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Signature of Applicant

State of _____ County of _____

Subscribed and sworn to before this _____ day of

_____, 20____, by _____
(Applicant name)

_____ _____
Signature of Notary Public Date Commission Expires

Wisconsin Department of Regulation & Licensing

Mail To: P.O. Box 8935
Madison, WI 53708-8935
FAX #: (608) 261-7083
Phone #: (608) 266-2112

1400 E. Washington Avenue
Madison, WI 53703
E-Mail: web@drl.state.wi.us
Website: http://www.drl.state.wi.us

DISCIPLINARY INQUIRIES REPORT

MEDICAL EXAMINING BOARD

(Not necessary if utilizing FCVS)

APPLICANT MUST COMPLETE THIS FORM AND FORWARD TO THE FEDERATION OF STATE MEDICAL BOARDS AT THIS ADDRESS:

FEDERATION OF STATE MEDICAL BOARD, INC.
FEDERATION PLACE
P.O. BOX 619850
DALLAS, TX 75261-9850

Attention: State Board Inquiries

The State of Wisconsin requests a Board Action Search concerning the following individual:

Practitioner's Name (Last, First, Middle) Degree

Date of Birth (month/day/year)

Medical School

Year of Graduation

Social Security Number

ECFMG #

Practitioner's Signature: _____

FEDERATION OF STATE MEDICAL BOARDS

The **State of Wisconsin** requests a disciplinary search concerning the above individual. **Please mail the response to the following address:**

Department of Regulation and Licensing
Medical Examining Board
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

#1445 (Rev. 03/03)
Ch. 448, Stats.

Wisconsin Department of Regulation & Licensing

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MEDICAL EXAMINING BOARD

NATIONAL PRACTITIONER DATA BANK

You are required to request the "Practitioner Request for Information Disclosure" (Self-Query) from the National Practitioner Data Banks web site:

www.npdb-hipdb.com

When you obtain your self query, **please, open the envelope** to be certain your application was processed.

Then forward the processed **original** report directly to the Medical Examining Board at the address listed below.

Questions regarding this form may be directed to the Data Bank Help Line at 1-800-767-6732.

Department of Regulation & Licensing
Medical Examining Board
PO Box 8935
Madison, WI 53708-8935

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CONVICTIONS AND PENDING CHARGES

If you have been convicted of a crime or have criminal charges pending against you, complete this form and return it with your application. Include a $6.00 Crime Information Bureau report fee in addition to your original application fees.

The Fair Employment Act (sections 111.31-111.395, Wis. Stats.) prohibits employment discrimination on the basis of conviction record or arrest record unless the circumstances of the conviction or arrest substantially relate to the circumstances of the particular job or licensed activity. The information requested on this form will be used to determine whether your application should be granted, approved with limitations, or denied. The information you provide on this form may be verified against criminal information records. Omission of information on this form will be considered a false statement on an application.

Profession you are applying for: _____

Last Name	First Name	MI	Former / Maiden Name(s)

Your Street Address (number, street, city, state, zip)

Mail To Address (if different)

Date of Birth	Social Security Number
month _____ day _____ year _____	Information helps us identify your record, but is voluntary. It is not available to the public.

Ethnic/gender information is required to check criminal information records.

Sex: ☐ M ☐ F

Ethnic: ☐ White, not of Hispanic origin ☐ Black, not of Hispanic origin ☐ Hispanic ☐ American Indian or Alaskan ☐ Asian or Pacific Islander ☐ Other

1. List all other names used: _____

2. List all felonies, misdemeanors, and other violations of state or federal law of which you have ever been convicted, in this state or any other, whether the conviction resulted from a plea of no contest or a guilty plea or verdict. For each, list the date and location of the conviction. Please include all convictions that involved alcohol or other drug use, including convictions for operating while intoxicated. Do not include municipal ordinance violations or other traffic offenses.

   It is your responsibility to submit certified copies of the police report or criminal complaint, judgment of conviction and sentencing, and verification of your compliance with all terms of each sentence, including chemical dependency assessments if ordered by the court. If the conviction is old and records have been destroyed, you must submit a written description of each offense, along with an explanation of the penalties imposed and verification that you completed all requirements.

OFFENSE	DATE	CITY/STATE

Attach additional sheet(s) if necessary.

Wisconsin Department of Regulation & Licensing

		YES	NO	MO/YR COMPLETED
3.	Have you ever been sentenced by a court to participate in an alcohol or other drug assessment, treatment or counseling program?	☐	☐	_____
	Did you successfully complete the program?	☐	☐	_____

Please attach the certificate of completion/discharge summary.

		(Check all that apply)	YES	NO	MO/YR COMPLETED
4.	Have you ever been sentenced to:	☐ Probation	☐	☐	_____
		☐ Parole	☐	☐	_____
		☐ Ordered to pay restitution	☐	☐	_____
	Did you successfully complete one of the above as ordered by the court?		☐	☐	_____

If you are <u>currently</u> on probation or parole, you must request your probation/parole officer to send a letter describing your current probation/parole requirements and your compliance with supervision.

5. List all felonies, misdemeanors, or other violations of state or federal law for which you have been arrested and which are **<u>pending</u>**. Submit a copy of the police report/criminal complaint for each of the following pending charges.

PENDING CHARGE	DATE OF ARREST	LOCATION OF ARREST (city/state)

Comments you wish to make regarding your convictions or pending charges. Attach another sheet if necessary.

_____

_____

_____

_____

AFFIDAVIT OF APPLICANT

I state that I am the person referred to in this document and that all the information which I provided above is true in every respect. I understand that false or forged statements made in this document in connection with my application for a credential, or failing to provide relevant information, may be grounds for denial of the application, revocation of the credential granted to me, or criminal prosecution. This document must be signed before a notary public.

_____ _____

Signature Date

Signed and sworn before me this _____ day of _____, 20 _____.

_____ _____

Signature of Notary Public Date

My commission (is permanent) _____ expires _____. **SEAL**

State of Wisconsin Department of Regulation & Licensing

CODES FOR SPECIALTIES:

ENTER **ONLY ONE** SPECIALTY CODE

Academic Medicine	37
Administrative Medicine	71
Aerospace Medicine	33
Alcoholism - Chemical Dependency	49
Allergy - Immunology	01
Anesthesiology	02
Aviation Medicine	32
Dermatology	03
Emergency Medicine	31
Endocrinology	56
Family Practice	41
Gastroenterology	06
General Practice	08
Genetics	61
Geriatrics	29
Hand Surgery	64
Hebiatrics	46
Hematology	07
Hyperbaric Medicine	65
Immunology - Infectious Diseases	47
Institutional Medicine	39
Internal Medicine	04
Internal Medicine - Cardiology	05
Internal Medicine - Pulmonary Medicine	45
Neonatology	63
Nephrology	40
Neurology	10
Neurophysiology	51
Nuclear Medicine	23
Obstetrics and Gynecology	12
Occupational Medicine	30
Oncology	38
Ophthalmology	13
Orthopedic Surgery	14
Otolaryngology	67
Otorhinolaryngology - Ent	15
Pain	66
Pathology	16
Pathology - Clinical	17
Pathology - Surgical Anatomic	72
Pediatrics	18
Pediatrics - Other	60
Perinatology	62
Pharmacology - Clinical	48
Physical Medicine and Rehabilitation	19
Preventive Medicine	09
Proctology	36
Psychiatry	20
Psychiatry - Child	21
Public Health	22
Radiation - Oncology	70
Radiology	53
Radiology - Diagnostic	43
Radiology - Nuclear Medicine	68
Radiology - Ultrasound	69
Research	34
Retired	24
Rheumatology	57
School Physician	52
Surgery - Cardiovascular	44
Surgery - Colon and Rectal	54
Surgery - General	25
Surgery - Maxillofacial	58
Surgery - Neurological	11
Surgery - Peripheral Vascular	59
Surgery - Plastic	26
Surgery - Thoracic	27
Urology	28

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NOTICES

TIME FOR REVIEW AND DETERMINATION OF CREDENTIAL APPLICATIONS

Generally, a credentialing authority is required to make a determination on an original application for a credential within 60 business days after a completed application is received.[a] An application is completed when all materials necessary to make a determination on the application and all materials requested by the licensing authority have been received.

PROCEDURES ON APPLICATION DENIAL

An applicant who receives a notice of denial may request a hearing to challenge the denial by filing a request with the appropriate board or the department within 45 days after the mailing of the notice of denial. The request must contain the applicant's name and address, the type of license sought, the reasons why a hearing is requested and a description of the mistake the applicant believes was made, if the applicant claims that the denial was based on a mistake of fact or law. Hearing procedures are specified in ch. RL 1 of the Wisconsin Administrative Code. A copy of ch. RL 1 is available at most public libraries, on the Internet through the index at *http://www.legis.state.wi.us/rsb/code/rl/rl.html* and may also be obtained from the department.

MAILING ADDRESS AND CHANGE OF ADDRESS

Credential holders may use a business address as a mailing address for department mail. A change of address must be reported to the department within 30 days.

PERSONALLY IDENTIFIABLE INFORMATION: USE AND AVAILABILITY

Information collected on an application form is required and will be used to determine eligibility for a credential or examination. It is not likely that the department will use information collected by these forms for other purposes.

Credentialing is a public process with a goal of identifying those competent to protect the public. The name, city, and status of credential holders are accessible at the Department's website at *http://www.drl.state.wi.us/* under "Credential Holder Query." Information collected on application and examination forms is available for inspection to the public under Wisconsin laws governing public records.

AMERICANS WITH DISABILITIES ACT

The Department complies with the Americans With Disabilities Act of 1990. The Department will make reasonable modifications to policies, practices and procedures when modifications are necessary to avoid discrimination on the basis of disability and will make reasonable accommodations necessary to provide a qualified individual with a disability with equal access to department programs.

Communications and examinations: Individuals who need auxiliary aids for effective communication in programs and services or who wish to request special accommodations for examinations, please call (608) 266-2852 or TTY at (608) 267-2416.

Complaints: Procedures for alleging violations of the Americans with Disabilities Act of 1990 may be obtained by calling the Department's ADA Coordinator at (608) 266-8608 or TTY at (608) 267-2416.

#1988 (Rev. 11/19/02) ss. 15.04 (1) (m), 19.35, Stats.

[a] Section RL 4.06 of the Wisconsin Administrative Code

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APPLICATION PACKET ADDENDUM (INTERNET)

MD and DO Re-Registration application packet

For the application packet that you have just downloaded, there are additional materials needed.

Please complete this form and fax it to the number listed above. Once the form is returned we will mail the additional items to the address you have provided. If you prefer, you can mail this form directly to the Department of Regulation and Licensing, P.O. Box 8935, Madison, WI 53708.

Please indicate on this form if you have downloaded the Wisconsin Statutes and Code Book for this profession. ☐ Yes ☐ No

PLEASE PRINT OR TYPE

_____ _____
Full Name Daytime Phone Number

_____
Street Address

_____
PO Box

_____
City, State, Zip

Thank you.

#2612 (4/03)